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APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHO BEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

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STATE OF ART

Adolescent problem behaviours typically take the form of internalising or externalising behaviours. Compared to internalising behaviours, the domain of externalising behaviours and associated symptoms causes teachers and parents the most concern. A group of behavioural challenges known as "externalising behaviour problems" show up in a child's outward behaviour and indicate that the child is negatively interacting with the outside world[1]. Externalising disorders, including conduct disorder (CD), oppositional defiant disorder (ODD), and attention deficit disorders (ADD/ADHD), are amongst the most common disorders of childhood and adolescence and these disorders are of early onset. Amongst them conduct problems constitute a third to a half of all clinic referrals[2].

According to Mental Health Research conducted in India in 2005, psychosis, hysterical neurosis, and conduct disorder were the most common diagnoses among those aged 12 to 16. The term conduct disorder' describes a pattern of repeated and persistent misbehavior. This misbehavior is much worse than expected in a child of that age. The essential feature is a persistent pattern of conduct in which the basic rights of others and major age-appropriate societal norms and rules are violated[3].

Typical symptoms of conduct disorder in children and adolescents include physical aggression, bullying, truancy, lying, stealing, lack of tolerance, moody behavior, drug abuse, destruction of public property, forced sex, and others[4]. Along with this, these adolescents tend to dominate others, have disrespectful attitudes, lack empathy, often misinterpret the intentions of others, and lack impulse control[5]. Additionally, they have impaired association between behavior and its negative or positive outcomes due to decreased sensitivity towards reward and punishment[6].

Conduct problems cause significant distress for children, families, and schools, resulting in social and educational impairment[7]. In adulthood, adverse consequences encompass antisocial personality disorder, violent and criminal offences, and incarceration. Conduct problems during childhood also increase the likelihood of developing a number of issues as an adult, such as severe challenges with schooling, employment, and money, homelessness, abuse, and dependence on drugs, alcohol, and tobacco. It also increases the risk of developing physical health issues, such as infections, injuries, and compromised immune systems, as well as dental and respiratory issues, mental illnesses, and suicidal thoughts and actions[8].

Aggression

Aggression is ingrained in human nature, for better or worse. The ability to defend oneself from verbal or physical attacks aids in survival and adaptation. Aggressive behaviours like hitting, pushing, slapping, biting, kicking, spitting, and hair-pulling are fairly common in young children[9]. Most children learn to socialise and control their aggressive behaviours as they age. Interactions with caregivers have a significant impact on shaping children's behavioural repertoire towards more socially acceptable forms of defending one's rights and goods and expressing one's desires. Some children, however, fail to follow this path of socialisation and continue to exhibit aggressive and rule-breaking behaviour. These children may be classified as having psychiatric disruptive behaviour disorder, with conduct disorder being the most severe.

It is the expression of the aggressive behaviour itself that is an important predictor of behavioral health outcomes among those with conduct disorder. For example, aggressive behaviour (along with Oppositional Defiant Disorder) is a significant predictor for the development of conduct

disorder[10], of treatment outcome[11], and of impaired functioning[12,] andantisocial behaviors[13] extending into adulthood. Findings from a 22-year longitudinal study revealed that, while many childhood variables (e.g., low IQ, poor housing, lower parenteducation) were individually related to criminality in adulthood, these variables "did not add to predicting criminality once early aggression was considered"[13]. All of these studies show that there is a higher chance of ongoing psychosocial issues well into adulthood when antisocial behaviours (such as property destruction, physical fighting, and physical cruelty) are present in childhood[14]. Adolescents with severe behavioural issues support more aberrant ideals and objectives in social contexts, such as attributing responsibility for others' misbehaviour, emphasising the value of dominance and retaliation in social conflicts, and considering aggression as a more acceptable way to achieve goals.

Emotional Regulation

Gross[15] conceptualizes emotional regulation as the mechanisms that determine which emotions a person experiences, when they do, and how they are expressed. Drawing on this definition, Thompson[16] defines emotional regulation as "the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals". Gratz et al.[17] summarized emotion regulation as including:

i. Awareness and the capacity to understand emotions.
ii. The ability to accept one's emotions.
iii. Being able to control impulses while experiencing strong emotions.
iv. Being able to modulate one's emotional responses as per contextual demands or goals.

Also, it is noteworthy, that emotional regulation which includes the processes or attempts to regulate emotion, does not simply connote an adaptive form of emotion regulation. Emotion regulation could be adaptive or maladaptive by nature. One generally accepted definition of emotional dysregulation identifies it as patterns of emotional experience or expression that interfere with appropriate goal-directed activity[18]. A goal-directed activity or behaviour that is appropriate for the situation is situationally functional[19]. In other words, emotional dysregulation serves as a barrier to emotional goal attainment, whereas emotional regulation helps.

In early childhood, emotion regulation abilities have been found to have an impact on academic achievement[20] and externalising behaviours[21]. In middle childhood, emotion regulatory abilities were found to affect peer relationships[22] and psychopathology[23]. In young adulthood, emotion regulatory abilities have been found to influence the quality of romantic

relationships[24]. The review of Roll et al.[25] showed that there are several empirical studies in support of the hypothesis that emotion regulation may be compromised in children with conduct and antisocial behavior. Effective emotion regulation starts with emotional awareness, defined as attention to and insight in one's own emotional responses and functioning[26]. Insufficient emotional awareness may lead to handling unpleasant emotions with impulsive acting-out behavior, because of misinterpreted internal and external emotional cues[27]. Factor et al.[28] indeed found that self-reported impaired emotional awareness was associated with comorbid externalizing disorders in a child population. Emotional awareness influences the processes of emotion regulation; after becoming aware of emotions, one needs to label them correctly and decide which responses or behaviors are necessary/appropriate or need to be inhibited[15]. Children with conduct problems have been found to be less likely to inhibit emotional reactivity and use less effective or more inappropriate regulatory strategies[29]. Furthermore, McLaughlin et al.[30] concluded that emotion dysregulation is a strong predictor of aggressive behavior in an adolescent community sample and not vice versa.

Empathy

Empathy is defined broadly as the process by which individuals are able to recognize, understand, and share in or react to the emotional states of others[31]. Appropriate empathy development has long been considered vital to the acquisition of self-regulation skills and, as a result, to healthy socioemotional development[32]. Further, empathy has been shown to play a positive role in social learning and communication, prosocial behavior, and successful engagement in social-affiliative processes across the lifespan[33]. There is consensus that empathy comprises two primary components: affective empathy and cognitive empathy. Affective empathy refers to the emotional reaction in a person that is elicited by the emotions of others. This emotional responsiveness includes both emotional reactivity (i.e., negative arousal or distress experienced in response to another's emotions) and emotional contagion (i.e., sharing in the subjective experience of the emotion displayed by another)[34]. Alternatively, cognitive empathy refers to the ability to accurately recognize and identify another's emotions (i.e., emotion recognition) and to understand another's perspective (i.e., perspective-taking)[35]. As such, cognitive empathy is said to represent a more sophisticated, intentional, and cognitively complex phenomenon[31]. Further, it requires a number of complex cognitive functions, such as neurocognitive skills for accurately labelling emotional expressions, distinguishing between one's own and others' mental states

Empathy is thought to inhibit aggression through perspective-taking and empathic concern. Perspective-taking is likely to influence how the provocation is interpreted which may lead to reduced anger. When it comes to aggression, the observation of the victim's pain and distress may evoke empathic distress in emotionally responsive individuals. Whether empathic distress leads to sympathy (an other-oriented emotion) or personal distress (a self focused emotion) depends, in part, on self–other differentiation and regulatory skills. Individuals who are not emotionally responsive or not emotionally involved (by detest or lack of interest) may show no empathic distress, and therefore no cessation of aggression. Thus, empathy deficits could be critical for explaining why children and adolescents with conduct disorders are more likelyto show a severe pattern of aggressive and violent behavior[36]. The hypothesis that empathy

inhibits aggression implies that aggressive behavior may be reduced by enhancing empathic skills in antisocial individuals. Research suggests that training programs aimed to strengthen empathic skills are effective in reducing antisocial behavior in healthy children[37].

Parenting Practices

There is now considerable evidence that parenting practices are among the strongest predictors of conduct problems[38], with behavioural control and monitoring featuring prominently in the research. Harsh/ punitive discipline, inconsistent discipline, or timid discipline in childhood, has been associated with aggression and conduct problems in children[39]. Patterson's[40] model of coercive family processes is one of the most influential models of conduct problems, and has formed the basis of most behavioural interventions. This model is based on social learning theory and operant conditioning, and proposes two main processes by which conduct problems may develop. The first is parental modelling of antisocial and aggressive behaviour. The second is a process whereby parents and children engage in mutual escalation and fall into 'reinforcement traps. The role of ineffective parenting and coercive processes in childhood conduct problems is further illustrated by the effectiveness of parenting interventions. Parent management training[41] based on social-learning theory is the gold standard intervention for conduct problem[42], and has been recommended as the first-line of treatment in childhood[43]. A major focus of behavioural parent training is on modifying negative parenting behaviours that contribute to coercive parent-child interactions, increasing reinforcement of desirable behaviour, and providing consistent consequences for misbehaviour[44]. Indeed, PMT has been associated with improvements in parental distress, in addition to child behaviour[44]. Despite the success of such interventions for many families, however, researchers report that a quarter to a third do not benefit[45], and meta-analytic research indicates that treatment effects are within the small to medium range[44].

Children learn how to regulate their emotional responses through interactions with their most immediate social environment – usually their parents[46]. Parental factors that come together to influence and nurture a child's emotion regulation abilities have been discussed within the literature on parental emotion socialisation[47]. Emotion socialisation theory encompasses following family-based factors:

a) Children are influenced by their parents' own emotional understanding and regulation. Children observe parents, and model their emotion expression and regulation[48].
b) Parents' emotions impact children's emotions via the emotional climate of the home environment to which all family members, but particularly parents, contribute[49].
c) Children are influenced by parents' accepting or non accepting beliefs about emotions[50]
d) Parenting practices, such as how parents respond to, discuss, and manage their child's emotions affect children's emotional development[51].

Cross-sectional evidence shows that supportive parenting practices, characterised by acknowledging, validating, and coaching children around positive and negative emotions[52], are associated with secure parent-child attachment[53], and optimal child emotional and psychological functioning[54]. Conversely, unsupportive emotional socialization practices

(parent's dismissive, punitive, or permissive responses to their child's emotional expression) as key contributors to the development of children's behaviour problems due to their emotional regulation deficits[55,56]. Until recently, however, prevention programs typically delivered to parents have not focused on social emotional learning, but rather on changing parenting practices to better manage children's behavior and reduce aggression. Behavioral programs with a strong evidence-base demonstrating positive behavioral outcomes in some populations include Parent Management Training[57], The Incredible Years[58], and Triple P[59]. These interventions are based on theories about the influence of reinforcement (positive and negative) on children's behavior, and are less likely to teach parents about responding to children's emotional needs in ways that teach about emotions or assist the child to develop emotional competence. Parenting services that provide prevention and early intervention largely use behavioral programs because they are evidence-based (generally a requirement for funding) and have standardized means of delivery (training, manuals, supervision). However, community service providers have sometimes been reluctant to adopt programs that focus on controlling children's behavior[60] rather than addressing parents' emotional responsiveness (i.e., parenting warmth, sensitivity, empathy), when they need to provide assistance to parents who find it hard to connect at an emotional level with their child. An evidence-based and standardized program that targets children's emotional competence, assists parents to emotionally connect with their children, and fosters a positive parent child relationship would thus provide an important alternative, or complement, to behavioral parenting programs.

PROBLEM TO BE INVESTIGATED

The index study aims to study the application of integrated parent mediated psychobehavioral intervention on aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder. Conduct problems cause children, families and schools' considerable distress, and they result in social and educational impairment. These children (persistent disruptive, deceptive and aggressive behaviours) are highly likely to require clinical intervention. Such interventions offer an important opportunity to prevent a burden of poor health and social maladjustment in adulthood.

Researchers have identified deficits specific to the disorder in both child and parent subsystems. Child subsystem deficits include poor emotional regulation, inadequate theory of mind, limited awareness, and difficulty interpreting others' perspectives, leading to aggression. Parental subsystem factors include coercive parenting, communication issues, emotional dismissive parenting, and invalidating home environment. A parent mediated psychobehavioral approach addresses these deficits, improving compliance and patient's prognosis.

OBJECTIVES

1. To assess the application of parent mediated integrated psychobehavioral intervention on outcome measures including aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder.

2. To assess the association of change in outcome measures following parent mediated integrated psychobehavioral intervention with various socio-demographic and clinical variables in adolescents with conduct disorder.
3. To analyze the feedback of parents of adolescents with conduct disorder about the changes observed as a result of parent mediated integrated psychobehavioral intervention.

MOTIVATION FOR THE STUDY

Conduct disorder is one of the most difficult conditions to treat, because the disorder is complex and pervasive. The incidents of school violence in India and the increased rate of criminality in adults in India points to the urgency in studying conduct disorder and to come out with an intervention strategy to arrest the progress of the symptoms into the next level. Besides, several studies have shown the link between antisocial personality in adults and the presence of conduct disorder in these adults during their childhood or adolescent years. Conduct disorder if unchecked can cause serious harm to the healthy development of the next generation, mental health of spouses and families thereby affecting the society. The scope of the problem, together with the knowledge that it is highly stable and chronic in nature and that available treatments are often limited, provide strong arguments for the development of comprehensive and preventive approaches.

The intervention proposed integrates the components of Cognitive Behaviour Therapy, Dialectical Behaviour Therapy, Solution Focused Therapy, Parent Management Training, Regulation Focused Therapy and Emotion Socialisation Practices. These therapeutic approaches focus on behavioural and emotional regulation, strength of the individual, communication strategies, perspective taking, disciplinary strategies and making the environment emotionally validating for the adolescents. The module is built to incorporate all these parent and child subsystem factors for holistic growth of the adolescents.

HYPOTHESES

1. There will be no significant difference in the extent of various outcome measures including aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation at post intervention level (at the time of discharge) in adolescents with conduct disorder receiving parent mediated integrated psychobehavioral intervention with those receiving treatment as usual.
2. There will be no significant change in outcome measures including aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder after receiving parent mediated integrated psychobehavioral intervention, from pre-intervention (baseline) to post intervention.
3. There will be no significant change in outcome measures including aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder after receiving parent

mediated integrated psychobehavioral intervention, from post intervention to follow-up.

4. There will be no significant association of change in outcome measures following parent mediated integrated psychobehavioral intervention with various socio-demographic and clinical variables in adolescents with conduct disorder.
5. Parents of adolescents with conduct disorder reports that no changes were observed in the adolescents as a result of parent mediated integrated psychobehavioral intervention.

OUTCOME VARIABLES

Primary Outcome Variables: Change in aggression and parental report of problem behaviour and their perception of outcome/change.

Secondary Outcome Variables: Change in emotional regulation, empathy and parent emotional socialisation

METHODS AND MATERIALS

Venue of the Study: Erna Hoch Centre for Child and Adolescent Psychiatry, Central Institute of Psychiatry, Ranchi.

Study Design: The study will use a mixed method randomised control design.

Sampling Method*:* Samples will be enrolled in the study using purposive selection. Participants will be allocated in two groups by block randomization method. These participants will be randomly assigned to two groups using block randomization method (Block size = 4) with each participant in the block being assigned a sequential random number generated using sealed envelope software[61].

Sample: Sample size estimation was carried out using G*Power 3.1.9.2 for two groups with effect size as 0.25, power as 95% and p value at 0.05 level. The total sample size calculated for the current study is 44. The study will comprise 44 adolescents (with their parents). 22 adolescents shall receive the proposed parent mediated integrated psycho-behavioural intervention whereas the other group of 22 adolescents shall be in the treatment as usual group (TAU).

INCLUSION CRITERIA (ADOLESCENTS)

a) Adolescents diagnosed with conduct disorder (F91) as per ICD-10 Diagnostic Criteria for Research, WHO[62]
b) Adolescents in the age group of 10 years to 19 years
c) Adolescents who can comprehend Hindi and/or English language
d) Adolescents obtaining above Grade IV Intellectual Capacity (25th Percentile) in Raven's Standard Progressive Matrices[63]
e) Adolescents with at least a primary level of education

f) Adolescents giving assent for the study

INCLUSION CRITERIA (PARENTS)

a) Parents with at least a primary level of education
b) Parents who can comprehend Hindi and/or English language
c) Parents who are available for the specified sessions
d) Parents giving informed consent for the study

EXCLUSION CRITERIA (ADOLESCENTS)

a) Adolescents diagnosed with other comorbid psychiatric disorders except Hyperkinetic Disorder (F90) and Harmful Use of Psychoactive Substances (F1*x*.1)[62]
b) Adolescents diagnosed with organic brain disorder, or any medical/ neurological illness.
c) Children and adolescents obtaining less than the 25th percentile on Raven's Standard Progressive Matrices[63]

EXCLUSION CRITERIA (PARENTS)

a) Parents scoring ≥5 on General Health Questionnaire-28[64]
b) Parents currently on any psychiatric treatment
c) Parents diagnosed with organic brain disorder, or any medical/ neurological illness.
d) History of Antisocial Personality Disorder

TOOLS TO BE USED

1. ***Informed Consent Form:*** The Informed Consent will seek permission from participants' parents/caregiver and include information regarding the research purpose, process, duration, participant selection, voluntary participation, and confidentiality of the study, as well as a Certificate of Consent. The document would also outline the potential risks and benefits of the research, as well as the rights and responsibilities of the participants.

2. ***Assent Form:*** The Assent will seek permission from participants and include information regarding the research purpose, process, duration, participant selection, voluntary participation, and confidentiality of the study, as well as a Certificate of Consent.

3. ***Semi-Structured Socio-Demographic and Clinical Data Sheet:*** The following sociodemographic data will be collected using a semi-structured proforma created especially for the study- name, age, sex, education, religion, address, family income, family type, diagnosis of adolescent patient, duration of illness, past history of illness, and family history of illness. The information shall also include guardians' details with regards to age, education & occupation, chief complaints upon presentation, onset and course of illness and presence of any precipitating factor.

4. ***Standard Progressive Matrices (SPM)[63]***: It is used as a screening tool to identify an intellectual disability. The tests consist of 60 items divided into 5 sets. It can be

administered to individuals aged 8-65 years. A score equal or less than Grade IV will be kept as the criteria to rule out those with below-average intellectual functioning. About measures of reliability and consistency, split-half method estimates showed values ranging from .60 to .98 while Raven's provided test-retest coefficients for different age groups: .93 (<30 years), .88 (30-39 years), .87 (40-49 years), and .83 (>50 years)[63].

5. ***General Health Questionnaire – 28 (GHQ-28)[64]:*** The GHQ-28 is a self-report screening measure used to detect possible psychological disorders. The GHQ-28 identifies two main concerns: (1) the inability to carry out normal functions; and (2) the appearance of new and distressing phenomena[64]. Higher scores indicate a greater possibility of psychological distress. A score ≥5 has been reported to indicate probable cases of psychiatric disorder[65]. Robinson et al.[66] examined test-retest reliability of the GHQ-28 with a sample of 20 individuals (time since stroke not specified) and reported excellent 2-month test-retest reliability (r=0.90). Researchers reported excellent concurrent validity between the GHQ-28 total score and the Zung Self-Rating Depression Scale (r=0.86), Hamilton Depression Scale (r=0.88) and the Present State Examination (r=0.94).

6. ***Aggression Questionnaire (AQ)[68]:*** It is an updated version of the Buss-Durkee Hostility Inventory[67], a long-time standard for assessing anger and aggression. It is a brief measure, consisting of only 34 items scored on five scales: Physical Aggression (PHY), Verbal Aggression (VER), Anger (ANG), Hostility (HOS) and Indirect Aggression (IND). The total score is converted to T-scores, which indicate the severity of aggression. The norms of AQ are based on a standardization sample of 2138 individuals, aged 9-88. The internal consistency estimate of the test is 0.94 and test-retest reliability is 0.80.[68]

7. ***Difficulties in Emotion Regulation Scale (DERS)[17]:*** The DERS is a 36-item self-report measure designed to assess clinically relevant difficulties in emotion regulation. This scale measures an integrative conceptualization of emotion regulation as involving not just the modulation of emotional arousal, but also the awareness, understanding, and acceptance of emotions, and the ability to act in desired ways regardless of emotional state. Participants indicate on a Likert scale how often each item applies to themselves, with responses ranging from 1 (almost never) to 5 (almost always). Higher scores indicate greater difficulty with emotion regulation. It assesses six clinically relevant domains of emotion dysregulation: non acceptance of emotion responses (Non acceptance), lack of emotional awareness (Awareness), limited access to emotion regulation strategies (Strategies), difficulties engaging in goal directed behaviour when emotionally aroused (Goals), impulse control difficulties (Impulse), and lack of emotional clarity (Clarity). The DERS has demonstrated high internal consistency (α=.93) and test–retest reliability (r=.84 to .96). [17]

8. ***Perth Empathy Scale (PES)[69]:*** The PES is a 20-item self-report measure of empathy. It is designed to assess both the cognitive and affective components of empathy and do so across negative and positive emotions. Four subscale scores and three composite

scores can be derived from the measure, with higher scores indicating higher levels of empathy. A total score (overall empathy ability) can be used by adding up all the items. The original English version of the PES has demonstrated acceptable to good internal consistency reliability, with a Cronbach's alpha of ≥0.70 for its subscales and composite scores.

9. ***Revised Behaviour Problem Checklist (RBPC)[70]:*** RBPC was developed and standardized for use in the screening and clinical assessment of school age children in kindergarten through 12th grade, which approximately corresponds to an age range of 5 to 18 years. The checklist has 89 items and parents must respond on a 3-point rating scale. The total of raw scores are converted to T scores and interpreted across 6 subscales: conduct disorder, socialized aggression, attention problems, anxiety-withdrawal, psychotic behavior and motor tension.[70]

10. ***Coping with Adolescents' Negative Emotions Scale (CANES)[71]:*** CANES is designed to assess how parents typically respond to adolescents' negative emotions (Parent emotion socialisation). Parents rate each item on a 7-point response set (ranging from *very unlikely* to *very likely*), with ratings representing the likelihood of responding to a scenario involving their child's expression of a negative emotion in a particular way. There are 9 scenarios representing situations in which children would typically express negative emotion (e.g., "If my child falls off his/her bike and breaks it, and then gets upset and cries, I would") and six response options for each scenario, each which corresponds with a particular subscale. The subscales include: Expressive encouragement, Emotion focused reactions, Problem focused reactions, Punitive reactions, Minimisation reactions, and Distress reactions. The Expressive encouragement subscale was selected to assess supportive emotion socialisation practices. The Minimization and Punitive subscales were combined to represent an overall Emotion Dismissing subscale, which was used to assess emotion dismissing practices. The reliability estimates ranged from .69 for the Punitive reactions subscale to .85 for the Expressive encouragement subscale. [71]

PROPOSED INTERVENTION

Intervention Structure

Number of therapeutic sessions: 15;
Duration of each session: 60-90 minutes;
Frequency: 3 sessions per week;
Pre- assessment (at baseline): 1 session
Post assessment (at the time of discharge): 1 session
Follow-up (3 months after discharge): 1 session

MODULE FOR PROPOSED INTERVENTION

The study intervention is an integration of pre-established evidence-based treatments, with modifications based on literature findings.

The first phase of the intervention for adolescent subsystem is derived from *Cognitive Therapy Techniques for Children and Adolescents: Tools for Enhancing Practice*[72]*; Manual of Regulation-Focused Psychotherapy for Children (RFP-C) with externalizing behaviors: A psychodynamic approach*[73] *and Solution Focused Therapy Treatment Manual for Working with Individuals*[74].

Behavioral interventions in the treatment of most childhood problems are necessitated as they lack skills in self-regulation and will therefore gain a tremendous initial benefit by learning how to calm their feelings and control their behaviors. When adolescents are overwhelmingly angry they generally cannot attend to cognitions or emotions and will therefore struggle with the more sophisticated interventions. In addition, introducing behavioral approaches in the beginning phase of treatment builds rapport, increases the adolescent's motivation and engagement in treatment, expands coping repertoires, and primes youngsters for subsequent interventions[72]. Additionally, distress tolerance skills help adolescents accept and manage emotional discomfort. Emotional intolerance contributes to impulsivity, vulnerability, and poor self-regulation[75]. A number of descriptive reports have concluded that distress tolerance skills training portion of Linehan's dialectical behavior therapy (DBT), which encompasses teaching patients ways to change their emotional, behavioral, and sensory sets through various techniques in response to stress,can be successfully applied to adolescents with externalising behaviours.[76,77].

Elements of solution focused therapy were included as it is based on the premise thatindividuals build their reality based on a subjective view of their world.[78] as well as on recognizing and constructing one's strengths, capabilities and solutions to the problems as they occur[79]. Numerous studies have demonstrated its efficacy in managing childhood behavioural disorders[80,81]. Additionally, components of Hoffman's[73] regulation focused interventions were incorporated as it considers externalizing behaviors as expressions of maladaptive coping mechanisms (defenses) by the adolescent to protect him/herself from painful emotions. The aggressive symptoms protect the adolescent by masking and removing the painful emotions from the adolescent's consciousness. In this treatment approach, the clinician systematically addresses the avoidance mechanisms with the adolescents and discusses how the disruptive behavior helps the adolescent avoid painful emotions. And, eventually the clinician helps the adolescent find better ways to cope with these painful feelings.[82,83]

The second phase of the intervention for adolescent subsystem is borrowed from *Emotion Regulation in Children and Adolescents: A Practitioner's Guide*[84]. Roll et al.[25] found empirical studies supporting the hypothesis that emotion regulation may be compromised in children with conduct disorder. Effective emotion regulation starts with emotional awareness, defined as attention to and insight in one's own emotional responses and functioning[85]. Insufficient emotional awareness may lead to handling unpleasant emotions with impulsive acting-out behavior, because of misinterpreted internal and external emotional cues[86]. Also, adolescents with conduct problems have been found to be less likely to inhibit emotional reactivity and use appropriate regulatory strategies[87]. Therefore, the proposed module includes strategies for emotional awareness, emotional understanding, and empathy skills to address these deficits from the mentioned text.

Cross-sectional evidence shows that supportive parenting practices, characterised by acknowledging, validating, and coaching children around positive and negative emotions[88], are associated with secure parent-child attachment[89]. The proposed module includes techniques for parental subsystem from *Parent management training: Treatment for oppositional, aggressive, and antisocial behavior in children and adolescents*[41] and *Emotion regulation and parenting*[90].Parent management training is based on principles of operant conditioning and social-learning theory, and is the gold standard intervention for conduct problems[42], A major focus of behavioural parent training is on modifying negative parenting behaviours that contribute to coercive parent-child interactions, increasing reinforcement of desirable behaviour, and providing consistent consequences for misbehaviour[44]. While there is ample data supporting favourable behavioural results from behavioural programmes, it is unlikely that these programmes would instruct parents on how to respond to their children's emotional needs in a way that fosters emotional competence. Therefore, the proposed module included parenting practices that influence children's emotional development based on the emotional socialisation theory, such as how parents respond to, discuss, and regulate their child's emotions[51]. Three facets of emotion-related socialisation techniques were covered in the module: (1) parents' responses to their children's emotions; (2) parents' own emotional expression and regulation; and (3) parents' conversation about emotions[91]. This kind of standardised, evidence-based programme that focuses on children's emotional competency, helps parents connect emotionally with their kids, and cultivates a positive parent-child relationship would complement behavioral parenting programs.

Phase	Technique	Content of the Session
I (1-2 sessions)	Therapeutic Assessment and Therapeutic Alliance (Family Meeting)	● Introducing the therapist ● Problem free talk ● Contracting with the adolescent and parents ● Pre-session changes
	Goal Setting	● The Referral Question ● Miracle Question ● Applied Behaviour Analysis (Parents) ● Addressing participant's anxieties and navigating through divergences in parental and adolescent perspective to reach a common goal.
II (3-6 sessions)	Behavioural Activation	● Physical Catharsis, tailored to adolescent's aptitude and interest ● Identifying triggers to emotions using Know Your Anger Worksheet ● Distress Tolerance Skills
	Parental Management Training	● Reinforcements and Punishment ● Attending and Planned Ignoring ● Problem Solving and Communication Enhancement

		• Introducing Floor Time and using role play to enhance communication
	Solution Focused Approach (Family Meeting)	• Tracing "successful solutions and exceptions" (progress/ improvement) • Constructing solutions and exceptions using parent-child frame of reference
	Analysis of Avoidance	• Coping and Relationship Questions • Analysis of avoidance as a defense • Introducing externalising behaviour to avoid feared feelings and its effect on communication • Addressing avoidance using following questions: ▪ What is the feared feeling? ▪ Why is the feared feeling avoided?
III (7-12 sessions)	Identifying Emotions and rating emotional intensity	• Importance of identifying and rating emotions • Survey the various feelings through worksheets such as emotion dictionary, emotion charades • Rating emotional intensity using ladder game
	Expressing Emotions	• Benefits of effective emotional expression • Forms of Expression (facial, physiological, mental, cognitive) • Preparing a list of emotions and providing words for expression • Expressing emotions using tailored narrative techniques • Using Improv Emotions Game to practice emotional expression • Using your body to regulate emotions (PLEASE skills)
	Understanding Emotions	• Addressing challenges in expression of emotions • Collaboratively brainstorming creative ways to express • Recognizing others emotions using detective game
	Empathy Skills	• Reviewing emotions identified in others • Appreciating and sharing other's feeling using *Emotional Idol* and *Take One, Take Two*
	Emotional Coaching (Parents)	• Recognising emotion as an opportunity for intimacy and teaching • Helping the child verbally label the emotions • Listening empathically and validating the child's feelings • Emphasis on parents teaching the child emotional regulation such as slow breathing, relaxation, self-control, and safe expression of anger

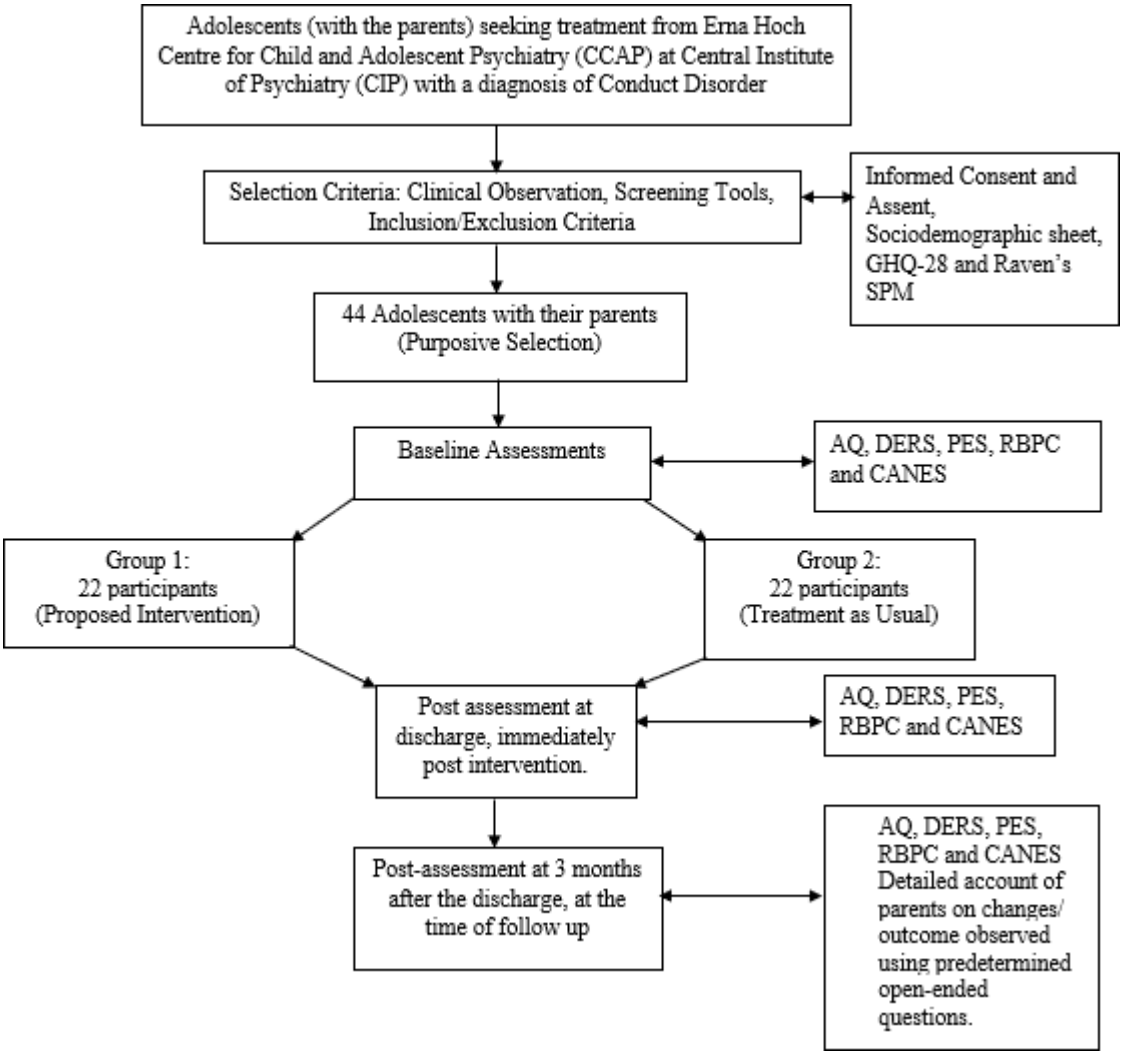
		● Parents are also taught skills in understanding and regulating their own emotions, and reflected on their family of origin experiences and how these influenced their beliefs and responses to emotions in themselves and their children.
IV (13-15 sessions)	Skill Review	● Evaluation of all the skills acquired ● Tracing the progress and factors responsible for it ● Summarize parent's involvement in treatment ● Parents as therapists for their child ● Summarize learnings from the program
	Termination	● Introducing termination ● Addressing anxieties associated with termination ● Adolescent's reaction and changes in behaviour after the news of termination ● Instilling hope and empowering the adolescent's self-efficacy
	Family Meeting	● Turning child's and parents focus to the goals achieved and realization that they are responsible for the progress ● Introducing changes and improvements to them along with the importance of compliments ● Informing the child and parents that it is their last session for the study, and offer resources if they wished to continue receiving therapeutic services

**** NOTE:** A pilot study was conducted to assess the feasibility of the intervention and outcome measures. Acceptability, engagement, comprehension, completion rate, adherence and retention were taken into consideration as feasibility indicators.

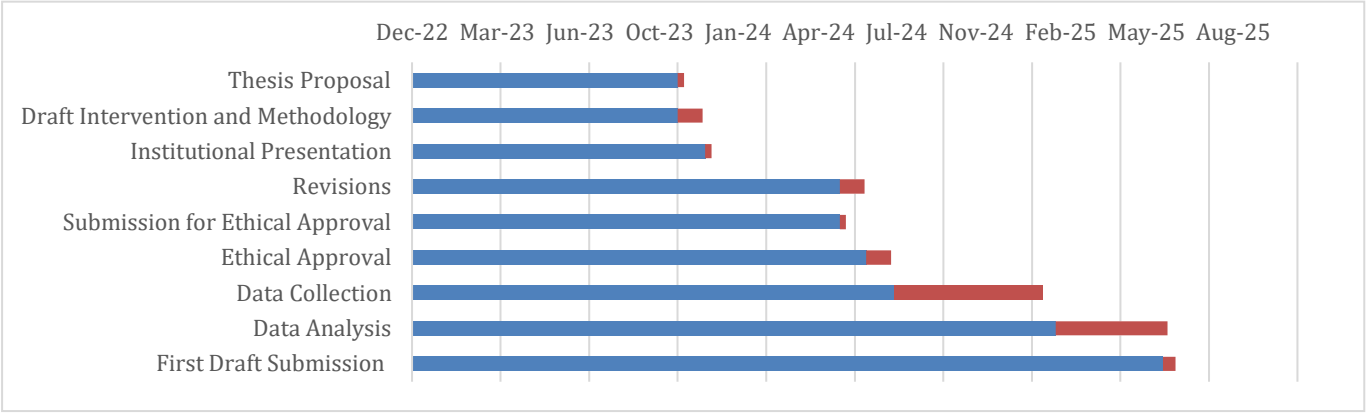
PROCEDURE

All the participants fulfilling the inclusion and exclusion criteria will be evaluated on the sociodemographic data sheet. The study group will receive proposed intervention whereas the control group will receive treatment as usual. All the participants will be evaluated at baseline, post intervention at discharge and 3 months post discharge on the following variables: aggression, emotional regulation, empathy, parental report of problem behaviours along with their perception of outcome or change and parent emotional socialisation. Generally, adolescents are driven by fantasy and this trait is pervasive in their nature. Therefore, thematic analysis is planned to assess the feedback of parents about the changes observed as it gives clues about who is going to sustain the benefits of the proposed module. A set of pre-determined open-ended questions will be asked from the parents about the progress at the follow-up and the responses will be recorded. The interview transcripts will be analysed

qualitatively to understand the parent's perception of outcome/ change observed in the adolescent.


Adolescents (with the parents) seeking treatment from Erna Hoch Centre for Child and Adolescent Psychiatry (CCAP) at Central Institute of Psychiatry (CIP) with a diagnosis of Conduct Disorder
Selection Criteria: Clinical Observation, Screening Tools, Inclusion/Exclusion Criteria
Informed Consent and Assent, Sociodemographic sheet, GHQ-28 and Raven's SPM
44 Adolescents with their parents (Purposive Selection)
Baseline Assessments
AQ, DERS, PES, RBPC and CANES
Group 1: 22 participants (Proposed Intervention)
Group 2: 22 participants (Treatment as Usual)
Post assessment at discharge, immediately post intervention.
AQ, DERS, PES, RBPC and CANES
Post-assessment at 3 months after the discharge, at the time of follow up
AQ, DERS, PES, RBPC and CANES Detailed account of parents on changes/ outcome observed using predetermined open-ended questions.

GANTT CHART



INTERIM STATISTICAL ANALYSIS

The statistical procedure will be completed by using Statistical Package for Social Sciences (SPSS) version 29.0. The demographic and other variables will be analysed using descriptive statistics. Paired t-test will be used to assess if there is any significant difference in the patients before and after receiving the integrated therapeutic intervention. Pre-post assessment and follow-up of both the groups will be analyzed by using repeated measures ANOVA. Pearson r-correlation will be used to assess the relationship between the variables.

Qualitative Analysis will be performed to analyze the feedback of parents of adolescents with conduct disorder about their perception of changes or improvements observed as a result of parent mediated integrated psychobehavioral intervention.

SIGNIFICANCE OF THE STUDY

Research in the field has identified multiple deficits in the children and adolescents with conduct disorder. Deficits unique to the child subsystem include those related to the serotonin and adrenergic systems, attribution biases, faulty problem-solving abilities, and inadequate processing of punishment, all of which manifest as aggression and acting out behaviour. In addition to their behavioural difficulties, these children often exhibit significant emotional deficits including poor emotional regulation skills, an inadequate theory of mind, limited emotional awareness, and trouble taking perspective of others. Along the parental subsystem, the following factors are identified as contributing to the development of conduct disorder: coercive parenting style, communication problems, emotionally dismissive parent, invalidating home environment[92]. To address these deficits, a psychobehavioral approach is necessitated in order to alleviate the problem behaviours while simultaneously creating awareness in clients about the factors responsible for it and strategies to regulate them, as it enhances compliance, improves current symptomatology and facilitate the active treatment of patients to improve their prognosis[93].

Several published guidelines[94-96] suggested the necessity for an effective intervention based on the certain principles (engage the family, develop strengths and solutions, accounting for child's psychobehavioral variables and offer multimodal interventions) in light of these risk factors and deficits. Considering the prevalence of conduct disorder and its impact on children and society, the current study is a novel attempt to construct an intervention module that seeks to integrate the therapeutic principles to address the psychological deficits. Emotional regulation in children and parental emotional socialisation practices are not only important in managing conduct disorder, but also in preventing the development of personality disorders, particularly antisocial personality disorder[97]. Parental involvement in the intervention also attempts to improve parent-child relationships, establish a systematic contingency management strategy in the home environment, and enable adolescent adaptive emotional development[98]. The current study is also significant at this moment in India, where there is a scarcity of studies on this topic. Furthermore, the proposed module can serve as a springboard for the creation of additional interventions required to lower the severity of conduct disorder and its progression to the next level.

RELEVANCE TO THE PRESENT-DAY PROBLEM AND NEED FOR THE SOCIETY

According to the 'Adolescent Mental Health' report of World Health Organization (WHO) 2018[99], onset age of half of the mental health disorders is 14 years, but most cases remain undiagnosed and untreated. Anxiety, depression, attention, hyperactivity, and behaviour disorders are the most common mental disorders among adolescents. Conduct disorder is the most significant disorder in the category of behavioural disorders as the cost of using public services in persons with conduct disorder was ten times that of those without it. The median 12-month prevalence rate of disruptive behaviour disorders (i.e., conduct disorder or oppositional defiant disorder) is 6% (range: 5%-14%) in studies conducted in India[100]. Compared to other phases of life, the adolescent stage is thought to be a fertile period of change since it carries with it the development of cognitive and affective skills, as well as physical and sexual maturation. Adolescents were chosen as the study's target group because intervention at this phase could mitigate the long-term outcomes and avert future psychopathology.

Conduct disorder often has severe consequences for others. The victims of conduct-disordered children and adolescents may include siblings, peers, parents, and teachers as well as strangers who are targets of antisocial and aggressive acts. As antisocial behavior continues in adulthood, there are many victims of acts of murder, rape, robbery, arson, drunk driving, and spouse and child abuse, which are carried out to a greater extent by persons with a history of antisocial behavior than by other persons[101]. Because of the many victims, conduct disorder plays a role unlike that of the vast majority of other psychiatric disorders. Consequently, effective treatment can have significant consequences for the community, beyond the person to whom it is directed.

Youth with conduct problems generate life-long costs because they traverse several systems including mental health, juvenile justice, special education, and social services. There is consensus amongst the professionals that the monetary costs of conduct disorder are exorbitant. Indeed, considering the course of dysfunction and the manifold systems through whichconduct-disordered youth traverse, conduct disorder may be the costliest mental health problem[102]. Its relevance to the modern day and society at large is highlighted by the degree ofimpairment that conduct disorder causes, both currently and in the future, as well as the costs to society incurred by the aggressive and criminal behaviour that people with the disorder occasionally demonstrate.

CONTRIBUTION TO THE EXISTING KNOWLEDGE

Multiple interventions have been adapted for conduct disorders such as Parent–Child Interaction Therapy[103], Parent Management Training[41], Problem Solving Skills Training programme, Regulation Focused Therapy[73], Multidimensional Family Therapy[104] and Multisystemic Therapy[105] and Cognitive Behaviour Therapy[72], Dialectical Behaviour Therapy[84]. While these therapeutic programs are quite effective in reducing conduct problems in young children, the effectiveness of these programs is substantially reduced in later childhood and adolescence[106]. Based on a comprehensive literature review of conduct disorder in adolescents and interventions for the same, the current study attempts to integrate therapeutic

techniques from the well-researched, manualized therapies so as to work on comprehensive recovery outcomes. There are other techniques such as solution focused and communication enhancement strategies for the holistic development of adolescents.

FUTURE WORK

The proposed model developed for conduct disorder can be applied to the population with other disruptive behaviour disorders as well and its effect on various outcome variables can be seen. Apart from focusing on outcome variables such as aggression, emotional regulation, empathy, problem behaviour and emotional socialisation, other variables such as impulsivity, academic attainment and social problem solving can also be added. The application of the intervention module can be assessed in various behavioural and emotional problems in childhood. The intervention module can also include cognitive restructuring techniques for the management of childhood depression and anxiety.

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APPENDIX-1

GOVERNMENT OF INDIA
CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

INFORMED CONSENT FORM

PROJECT TITLE: APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

Investigators' Details:

1. **Prof. (Dr) Amool Ranjan Singh,** M.Phil., Ph.D., Professor & Head, Department of Clinical Psychology, Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Kanke, Ranchi- 834006
2. **Dr Sourav Khanra,** M.D., DNB, Associate Professor of Psychiatry, Central Institute of Psychiatry, Kanke, Ranchi- 834006
3. **Ms. Kudrat Sachdeva,** M.Phil., CIP, Kanke, Ranchi

Participant Details:

1. Name:
2. Age/Date of Birth:
3. Name of the Informant/Guardian/Caregiver:
4. Address:

Patient/Guardian/Caregiver Consent Form

Part I: Information Sheet for Patient and/or Guardians/Caregivers

1. Purpose of Study: To study the application of parent mediated integrated psychobehavioral intervention on aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder.
2. Process of Study: In this study, data would be collected by proper and detailed evaluation of patients admitted to the hospital as per the inclusion and exclusion criteria mentioned and further statistical analysis would be performed to test the hypotheses.
3. Risk from the Study: Nil
4. Benefits from the Study: In this study, our aim is to study the application of parent mediated integrated psychobehavioral intervention on aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder.
5. Complications: Nil
6. Compensation: Nil
7. Confidentiality: Your participation in this study would be kept confidential. No data/part of data would be published with your name in it. By signing this consent from, you authorize investigative agency and Institute Ethics Committee to share the records related to you.

8. Rights of the Participants: For receiving treatment at CIP, Ranchi in future, you and your family has the right to withdraw your consent from the study during any part of the study without any reason.
9. Options for Participation in the Study: You can continue with the usual treatment what you have been receiving from CIP, Ranchi.

You can ask for more/further information during and/or after the completion of the study.

Part 2: Patient/Guardian/Caregiver Consent

I have read and have been explained the information contained in this form. I was given a chance to ask and put forth questions related to the study. I have been made satisfied completely. I hereby give my consent for participation in the Study. Name of the Patient:
Signature/Left Thumb Impression of Patient/Caregiver:

Date:

Relationship with the patient:

Testimony of the Investigator:

I, Ms. **Kudrat Sachdeva**, Investigator, have explained to the patient/caregiver in the language in which they are conversant. I have explained the procedure, benefits and harm of the study to them.

Signature of the Investigator:	Signature of the Witness:
Name of the Investigator:	Name of the Witness
Date:	Date:
(Signature/LTI of the guardian)	Name:
Date:	Place:

भारत सरकार

के न्द्रीय मनाचिककत्सा संस्थान

राँिी – 834006

सू ित सहमतत पत्र

परियोजना का शीर्क : **APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY**

जा ंिकत।

1. **Prof. (Dr) Amool Ranjan Singh,** M.Phil., Ph.D., Professor & Head, Department of Clinical Psychology, Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Kanke, Ranchi- 834006
2. **Dr Sourav Khanra,** M.D., DNB Associate Professor of Psychiatry, Central Institute of Psychiatry, Kanke, Ranchi- 834006
3. **Ms. Kudrat Sachdeva,** M.Phil., CIP, Kanke, Ranchi

प्रततभागी

नाम: उम्र/जन्म तिथि:

अभिावक का नाम: पिा:

रोगी / अभभभावक / अभभभावक सहमतत

भाग १: सू ना पत्र रोचगय ं / अभभभावक

के भिए

1. **अध्ययन का उद्देश्य**: आचिण ववकाि वाले ककशोि ं मे ं आक्रामक ि ा, ि ावनात्मक ववतनयमन, सहानु ू त ि, समस्या व्यवहाि की माि ा-वपिा की रि पोर्ष औि माि ा-वपिा के ि ावनात्मक समाजीकिण पि माि ा-वपि ा की मध्यस् ि ा वाले एकीकृ ि मनो-व्यवहाि हस्ि क्षेप के अनुप्रयोग का अध्ययन किना।

2. **अध्ययन प्रकियाएं**: इस अध्ययन के दौि ान ओपीडी या अस्पि ाल मे ं ि ी ि ोथगय ं मे ं, ववभिन्न

पैमाने के माध्यम से म यांकन औि म य न के बाद डेर्ा को इकट्ठा ककया जाएगा
ववस् ि ि ाक

औ सांख्ययकीय रूप से मलू याांकन ककया जाएगा।

3. **अध्ययन का जोखिम**: श य

4. **अध्ययन के िाभ**: इस अध्ययन से हम िोथगयों में मनोवैज्ञातनक औि मानभसक लक्षण का अध्ययन कि ंगे, जो ि क्ष सांग ि े ि े पी औि बेह ि ि प्रबंधन मे ं औि मदद कि ंगे।
5. **जट ि ि त ायें**: श य
6. **न सान भरपाई:** श य
7. **गोपनीयता**: आपकी अध्ययन की ि ागीदाि ी का रिकॉडष गोपनीय ि खा जाएगा। डेर्ा का कोई ि ीप्रकाशन आपके नाम से नहीं ककया जाएगा। सहमति फॉमष पि हस्ि ाक्षि किके , आप तनयामक प्राधधकिणों औि सांस्ि ागि नैतिक सभमत ि को अपने अध्ययन से सांबांधध ि थचककत्सा रिकॉड साझा किने का अधधकाि दे ि े हैं।
8. **प्रततभाचगयों के अच ि कार**: आपको सी०आई०पी० मे ं ि ववष्य के उपचाि से गुज ि ने के भलए आपके

   या आपके परिवाि के अधधकाि ियों के ाषग्रह के बबना अध्ययन के दौि ान ककसी ि ी समय ककसी ि ी प अध्ययन से बाहि तनकलने का अधधकाि है।

9. **अध्ययन में भागीदारी के ववकल्प**: आप अस्पिाल से सामान्य रूप से इलाज जाि ी ि ख सकि हैं। अध्ययन के दौि ान या उसके बाद ककसी ि ी समय, आप अध्ययन के बाि े मे ं औि जानकाि ी प्राप्ि ि कि सकि हैं.

भाग २: रोगी / अभभभावक / अभभभावक सहमतत

मुझे अध्ययन को समझाया गया है औि इस फॉमष की सामग्री पढी है । मुझे प्रश्न पूछने औि उन्हें ि खने का मौका ददया गया है औि मैं ुप्र हूूँ।
इससे स ि

मैं अध्ययन मे ं द ाख ि ि ा ि े ने
के भि ए त ैयार हू

ि ोगी का नाम:

े का तनशान:

ि ोगी / देखिाल किने वाले का
हस्ि ाक्षि/बाएूँ अां ठ

ददनाांक:

ि ोगी के साि सांबांध:

जां ि कत ा का बयान:

मैं जाूँचकि ा, **Ms. Kudrat Sachdeva** ने मा ि ा-वपिा / अभि ि ावक को उसी ि ार्ा

मेंं समझाया है, खजसे
वह समझिे है। मने अध्ययन की प्रक्रिया, लाि औि हातन को
समझा ददया है । जाांचकिाा का हस्िाक्षि: साक्षी का हस्िाक्षि:
जाांचकिाा का नाम: साक्षी का नाम:
तिथि: तिथि:

APPENDIX-2

GOVERNMENT OF INDIA

CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

ASSENT FORM

Title: APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

Investigators' Details:

1. **Prof. (Dr) Amool Ranjan Singh,** M.Phil., Ph.D., Professor & Head, Department of Clinical Psychology, Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Kanke, Ranchi- 834006
2. **Dr Sourav Khanra,** M.D., DNB Associate Professor of Psychiatry, Central Institute of Psychiatry, Kanke, Ranchi- 834006
3. **Ms. Kudrat Sachdeva,** M.Phil., CIP, Kanke, Ranchi

Participant Details:

1. **Name:**
2. **Age/Date of Birth:**
3. **Name of the Informant/Guardian/Caregiver:**
4. **Address:**

Part 1: Information Form

1. My name is_____and my job is to find out application of parent mediated integrated psychobehavioral intervention on aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder.

I am going to brief you and invite you to be part of a research study. You can choose whether you want to participate or not. We have discussed this research with your parent/guardian and they are aware that we are asking you for your consent as well. If you are going to participate in the research, your parent/guardian will also need to agree. But if you don't want to participate in the research, you don't have to do so even if your parents agree. There may be some words you don't understand or there are things you want me to explain more about. Please ask me to stop anytime.

2. **Purpose of study:** To study the application of parent mediated integrated psychobehavioral intervention on aggression, emotional regulation, empathy, parental report of problem behaviours and parent emotional socialisation in adolescents with conduct disorder.

3. **Participation is voluntary**: You don't have to be in this research if you don't want to be. Its up to you. If you decide not to be in the research, its okay and nothing changes. This is still your clinic, everything stays the same as before. Even if you say "yes" now, you can change your mind later.

4. **Procedure: What will happen in treatment**: We will meet once or twice every week and we speak about your concerns currently e the problems that you are facing. We will use some interesting activities and methods which will help you become better and happier.

5. **There is no risk or harm to you**. We will not tell other people that you are in this research and we won't share information about you to anyone who does not work in the research study. After the research is over, you will know about the results.

You can ask me questions now or later. I have written a number and address where you can reach us or, if you are nearby you can come and see us. If you want to talk to someone else that you know like your teacher or doctor or friend, that's okay too.

PART 2: Certificate of Assent

I have read this information (or the examiner has given me the information). I have my questions answered and I know I can ask later if I have questions.
I agree to participate in the research.

Name of participant:

_____

Participant's signature:

_____

Date:

I have the participant read or view the consent form correctly, and the person has had the opportunity to ask questions. I confirm that the individual has freely consented.

Name of the researcher

_____

Researcher's signature

_____

Date

भारत सरकार

के न्द्रीय मनाचिककत्सा संस्थान

रांि ी-834006

स्वीकृ तत पत्र

पररयोजना का शीर्क : **APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY**

जा ंि कत ा

1) **Prof. (Dr) Amool Ranjan Singh,** M.Phil., Ph.D., Professor & Head, Department of Clinical Psychology, Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Kanke, Ranchi- 834006
2) **Dr Sourav Khanra,** M.D., DNB Associate Professor of Psychiatry, Central Institute of Psychiatry, Kanke, Ranchi- 834006
3) **Ms. Kudrat Sachdeva,** M.Phil., CIP, Kanke, Ranchi

प्रततभागी

नाम:

ि ोगी का नाम:

उम्र / जन्म तिथि: पिा:

सां ि ावि तनथध एजेंसी:

भाग ।: स ना पत्र

1. मे ि ा नाम _____ है औ मे ि ा काम यह प ि ा लगाना है कक आच ि ण ववकाि वाले ककशोि ि ों मे ं आक्रामक ि ा, ि ावनात्मक ववतनयमन, सहानु ि ूत ि , समस्या व्यवहाि की माि ा-वप ि ा की रिपोर्ष औ माि ा-वपिा के ि ावनात्मक समाजीक ि ण पि माि ा-वप ि ा की मध्यस् ि ि ा वाले एकीकृ ि मनो-व्यवहाि हस्ि क्षेप का अनुप्रयोग।

मैं आपको जानकारी देने जा रहा हूां औि आपको एक शोध अध्ययन का दहस्सा बनने के भलए आमांबित किया हूां। आप चुन सकते हैं कक आप िाग लेना चाहते हैं या नहीं। हमने आपके माता-पिता/अभिभावक के साथ इस शोध पि चचा की है औि वे जानते हैं कक हम आपसे आपकी सहमतत के भलए किी पि रहे हैं।

यदद आप शोध में िाग लेने जा रहे हैं, तो आपके माता-पिता/अभिभावक को किी सहमत होना होगा। लेककन यदद आप शोध में िाग नहीं लेना चाहते हैं, तो आपके माता-पिता सहमत होने पि किी आपको

ऐसा किने की आवश्यकता नहीं है कु छ ऐसे शब्द हो सकते हैं ख्जन्हें आप नहीं समझते हैं या ऐसी चीजें हैं ख्जनके बाते में आप चाहते हैं कक मैं इसके बाते में अथधक समझाऊां । कृ पया मुझे ककसी िी समय रुकने के भलए कहें

2. **अध्ययन का उद्देश्य:** आचिण ववकाि वाले ककशोिों में आक्रामकता, िावनात्मक ववतनयमन, सहानुिूतत, समस्या व्यवहाि की माता-पिता की रिपोर्ष औि माता-पिता के िावनात्मक समाजीकिण पि माता-पिता की मध्यस्तता वाले एकीकृ त मनो-व्यवहाि हस्तक्षेप के अनुप्रयोग का अध्ययन किना।

3. **भागीदारी स्वैच्छिक है:** यदद आप नहीं बनना चाहते हैं तो आपको इस शोध में शाभमल होने की आवश्यकता नहीं है। यह आप पि तनिा किता है। यदद आप शोध में शाभमल नहीं होने का तनणय लेते हैं, तो ठीक है औि कु छ िी नहीं बदला होगा। यह अिी िी आपका ख्खलतनक है, सब कु छ पहले जैसा ही िहता है। यहाां तक कक अगि आप अिी "हाां" कहते हैं, तो आप बाद में अपना ववचाि बदल सकते हैं।

4. **प्रकिया:** इलाज में लया होगा: हम हि हफ्ते एक या दो बाि भमलेंगे औि हम आपकी थचंताओां के बाते में बाि किते हैं औि विमान में आप ख्जन समस्याओां का सामना कि िहे हैं। हम कु छ ददलचस्पगतिववधयों औि तकनीकों का उपयोग किेंगे जो आपको बेहति औि खुश िहने में मदद किेंगे।

5. आपको कोई खतिा या नकसान नहीं है। हम अन्य लोगों को यह नहीं बताएंगे कक आप इस शोध में हैं औि हम आपके बाते में जानकािी ककसी ऐसे व्यक्ति से साझा नहीं किेंगे

जो शोध अध्ययन में काम नहीं किया है। शोध समाप्ति होने के बाद, आपको परिणामों के बारे में पता चल जाएगा।

आप मुझसे अभी या बाद में प्रश्न पूछ सकते हैं। मने एक नांबि औ पिा भलखा है जहाूँ आप हम िक पहुूँच सकते हैं या यदद आप पास हैं, तो आप आकि हमें देख सकते हैं। अगि आप ककसी ऐसे व्यक्ति से बाि किना चाहते हैं ख़ुजसे आप अपने भशक्षक या डॉक्टर्ि या दोस्ति की तिह जानते हैं, तो िी कोई बाि नहीं।

भाग 2: सहमतत का प्रमाण पत्र

मने यह जानकाि ी पढ ली है (या पिीक्षक ने मुझे जानकाि ी बिा दी है)। मेि े पास मेि े सवालों का जवाब है औि मैं जानिा हूां कक अगि मेि े पास प्रश्न हैं ि ो मैं बाद सकिा हूां।

में पमैं शोध में ि ाग लेने के भलए सहमि हूां।

प्रतिि ागी का नाम:

प्रतिि ागी के हस्ि ाक्षि:

ददनाांक:

मने सहिाग ी क ो सहमत ि प्रपि क ा सह ी-सह ी पढ ा या द े ख ा ह ै, ने का अवसि

औि व ्यख्ल ि क ो प्रश ्न प भमल ा ह ै। म ैं प ुष ्ष ्र ि ि ा ह ू ां कक

व ्यख्ा ि ने स ्व ि ाां ि रूप स े सहमत ि द ी ह ै।

शोधक ि ाम क ा नाम:

शोधक ि ाम क े हस्ि ाक्षि:

ददनाांक:

APPENDIX-3

GOVERNMENT OF INDIA
CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

SOCIO-DEMOGRAPHIC AND CLINICAL DATA SHEET

Serial No.: Date:
CRF No.: UHID:
Name: Address:

Socio-Demographic Sheet (Adolescent Patient)

Age:			
Sex:	Male ☐	Female ☐	
Education:	Primary ☐	Secondary ☐	
Domicile:	Rural ☐	Urban ☐	Sub-Urban ☐

Religion:	Hindu ☐	Muslim ☐	Christian ☐	Others ☐
Family Type	Nuclear ☐	Joint ☐	Extended ☐	
Number of siblings and Sibling Order:				
Family Income (Rupees/Month):				
Socio-Economic Status	Lower ☐	Middle ☐	Upper ☐	

Socio-Demographic Sheet (Parent/Caregiver)

Relation	**Name**	**Age (Yrs.)**	**Education**	**Occupation**
Mother				
Father				

Clinical Data Sheet

Diagnosis as per ICD-10 (DCR):				
Department of Treatment	Outpatient ☐	Inpatient ☐		
Age at the time diagnosis (in years)				
Duration of Illness (in years):				
Chief Complaints (Target behaviours):				
Course	Continuous ☐	Episodic ☐	Fluctuating ☐	
Precipitating Factor (if any):				
Family History	Medical ☐	Psychiatric ☐	Details:	
Birth and Developmental History				
Premorbid Temperament	Easy ☐	Slow -to-warm ☐	Difficult ☐	
Comorbid Illness: Current/ Lifetime				
Number of Admissions (in any Child Guidance Centre)				
Treatment History	Treatment Naive ☐	Pharmacotherapy Past: Current:	Psychotherapy ☐	Details:

APPENDIX-4

GOVERNMENT OF INDIA
CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

ANSWER-SHEET
OF
STANDARD PROGRESSIVE MATRICES

SETS A, B. C, D, & E

NAME----------GROUP NO.----------

PLACE---------- DATE----------

AGE----------BIRTHDAY----------

TEST BEGUN----------TEST ENDED----------

A	A	B	B	C	C	D	D	E	E
A-01		B-01		C-01		D-01		E-01	
A-02		B-02		C-02		D-02		E-02	
A-03		B-03		C-03		D-03		E-03	
A-04		B-04		C-04		D-04		E-04	
A-05		B-05		C-05		D-05		E-05	
A-06		B-06		C-06		D-06		E-06	
A-07		B-07		C-07		D-07		E-07	
A-08		B-08		C-08		D-08		E-08	
A-09		B-09		C-09		D-09		E-09	
A-10		B-10		C-10		D-10		E-10	
A-11		B-11		C-11		D-11		D-11	
A-12		B-12		C-12		D-12		E-12	
TOTAL									

AGE----------TOTAL----------

GRADE----------PERCENTILE----------

SIGNATURE OF TESTER----------

APPENDIX-5

GOVERNMENT OF INDIA
CENTRAL INSTITUTE OF PSYCHIATRY
RANCHI-834006

APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER

GENERAL HEALTH QUESTIONNAIRE-28

HAVE YOU RECENTLY:

1. Been feeling perfectly well and in good health?
2. Been feeling in need of a good tonic?
3. Been feeling run down and out of sorts?
4. Felt that you are ill?
5. Been getting any pains in your head?
6. Been getting a feeling of tightness or pressure in your head?
7. Been having hot or cold spells?
8. Lost much sleep over worry?
9. Had difficulty in staying asleep once you are off?
10. Felt constantly under strain?
11. Been getting edgy and bad-tempered?
12. Been getting scared or panicky for no good reason?
13. Found everything getting on top of you?
14. Been feeling nervous and strung-up all the time?
15. Been managing to keep yourself busy and occupied?
16. Been taking longer over the things you do?
17. Felt on the whole you were doing things well?
18. Been satisfied with the way you've carried out your task?
19. Felt that you are playing a useful part in things?
20. Felt capable of making decisions about things?
21. Been able to enjoy your normal day-to-day activities?
22. Been thinking of yourself as a worthless person?
23. Felt that life is entirely hopeless?
24. Felt that life isn't worth living?

25. Thought of the possibility that you might make away with yourself?
26. Found at times you couldn’t do anything because your nerves were too bad?
27. Found yourself wishing you were dead and away from it all?
28. Found that the idea of taking your own life kept coming into your mind?

APPENDIX-6

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APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

AGGRESSION QUESTIONNAIRE

Circle one response number for each statement.					
Not at all like me	A little like me	Somewhat like me	Very much like me	Completely like me	
1	2	3	4	5	1. My friends say that I argue a lot.
1	2	3	4	5	2. Other people always seem to get the breaks.
1	2	3	4	5	3. I flare up quickly, but get over it quickly.
1	2	3	4	5	4. I often find myself disagreeing with people.
1	2	3	4	5	5. At times I feel I have gotten a raw deal out of life.
1	2	3	4	5	6. I can't help getting into arguments when people disagree with me.
1	2	3	4	5	7. At times I get very angry for no good reason.
1	2	3	4	5	8. I may hit someone if he or she provokes me.
1	2	3	4	5	9. I wonder why sometimes I feel so bitter about things.
1	2	3	4	5	10. I have threatened people I know.
1	2	3	4	5	11. Someone has pushed me so far that I hit him or her.
1	2	3	4	5	12. I have trouble controlling my temper.
1	2	3	4	5	13. If I'm angry enough, I may mess up someone's work.
1	2	3	4	5	14. I have been mad enough to slam a door when leaving someone behind in the room.
1	2	3	4	5	15. When people are bossy, I take my time doing what they want, just to show them.
1	2	3	4	5	16. I wonder what people want when they are nice to me.
1	2	3	4	5	17. I have become so mad that I have broken things.
1	2	3	4	5	18. I sometimes spread gossip about people I don't like.
1	2	3	4	5	19. I am a calm person.
1	2	3	4	5	20. When people annoy me, I may tell them what I think of them.
1	2	3	4	5	21. I sometimes feel that people are laughing at me behind my back.
1	2	3	4	5	22. I let my anger show when I do not get what I want.
1	2	3	4	5	23. At times I can't control the urge to hit someone.
1	2	3	4	5	24. I get into fights more than most people.
1	2	3	4	5	25. If somebody hits me, I hit back.
1	2	3	4	5	26. I tell my friends openly when I disagree with them.
1	2	3	4	5	27. If I have to resort to violence to protect my rights, I will.
1	2	3	4	5	28. I do not trust strangers who are too friendly.
1	2	3	4	5	29. At times I feel like a bomb ready to explode.
1	2	3	4	5	30. When someone really irritates me, I might give him or her the silent treatment.
1	2	3	4	5	31. I know that "friends" talk about me behind my back.
1	2	3	4	5	32. Some of my friends think I am a hothead.
1	2	3	4	5	33. At times I am so jealous I can't think of anything else.
1	2	3	4	5	34. I like to play practical jokes.

APPENDIX-7

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APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

*

Difficulties in Emotion Regulation Scale (DERS)

Instructions:

Please press the response that is most true for you.

		Almost Never	Sometimes	About half the time	Most of the time	Almost always
1	I am clear about my feeling	5	4	3	2	1
2	I pay attention to how I feel	5	4	3	2	1
3	I experience my emotions as overwhelming and out of control	1	2	3	4	5
4	I have no idea how I am feeling	1	2	3	4	5
5	I have difficulty making sense out of my feelings	1	2	3	4	5
6	I am attentive to my feelings	5	4	3	2	1
7	I know exactly how I am feeling	5	4	3	2	1
8	I care about what I am feeling	5	4	3	2	1
9	I am confused about how I feel	1	2	3	4	5
10	When I'm upset, I acknowledge my emotions	5	4	3	2	1
11	When I'm upset, I become angry with myself for feeling that way	1	2	3	4	5
12	When I'm upset, I become embarrassed for feeling that way	1	2	3	4	5
13	When I'm upset, I have difficulty getting work done	1	2	3	4	5
14	When I'm upset, I become out of control	1	2	3	4	5
15	When I'm upset, I believe that I will remain that way for a long time	1	2	3	4	5
16	When I'm upset, I believe that I'll end up feeling very depressed	1	2	3	4	5
17	When I'm upset, I believe that my feelings are valid and important	5	4	3	2	1

*

		Almost Never	Sometimes	About half the time	Most of the time	Almost always
18	When I'm upset, I have difficulty focusing on other things	1	2	3	4	5
19	When I'm upset, I feel out of control	1	2	3	4	5
20	When I'm upset, I can still get things done	5	4	3	2	1
21	When I'm upset, I feel ashamed with myself for feeling that way	1	2	3	4	5
22	When I'm upset, I know that I can find a way to eventually feel better	5	4	3	2	1
23	When I'm upset, I feel like I am weak	1	2	3	4	5
24	When I'm upset, I feel like I can remain in control of my behaviours	5	4	3	2	1
25	When I'm upset, I feel guilty for feeling that way	1	2	3	4	5
26	When I'm upset, I have difficulty concentrating	1	2	3	4	5
27	When I'm upset, I have difficulty controlling my behaviours	1	2	3	4	5
28	When I'm upset, I believe that there is nothing I can do to make myself feel better	1	2	3	4	5
29	When I'm upset, I become irritated with myself for feeling that way	1	2	3	4	5
30	When I'm upset, I start to feel very bad about myself	1	2	3	4	5
31	When I'm upset, I believe that wallowing in it is all I can do	1	2	3	4	5
32	When I'm upset, I lose control over my behaviours	1	2	3	4	5
33	When I'm upset, I have difficulty thinking about anything else	1	2	3	4	5
34	When I'm upset I take time to figure out what I'm really feeling.	5	4	3	2	1
35	When I'm upset, it takes me a long time to feel better	1	2	3	4	5
36	When I'm upset, my emotions feel overwhelming	1	2	3	4	5

Developer Reference:

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. Journal of psychopathology and behavioral assessment, 26(1), 41-54.

APPENDIX-8

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APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

PES

Name: **Date:**

This questionnaire asks about how easily you recognise and experience the emotions of others. Please score the following statements using the scale provided. Circle one answer for each statement.

		Almost never	Sometimes	About half the time	Most of the time	Almost always
1	Just by seeing or hearing someone, I know if they are feeling sad.	1	2	3	4	5
2	When I see or hear someone who is sad, it makes me feel sad too.	1	2	3	4	5
3	Just by seeing or hearing someone, I know if they are feeling happy.	1	2	3	4	5
4	When I see or hear someone who is happy, it makes me feel happy too.	1	2	3	4	5
5	Just by seeing or hearing someone, I know if they are feeling angry.	1	2	3	4	5
6	When I see or hear someone who is angry, it makes me feel angry too.	1	2	3	4	5
7	Just by seeing or hearing someone, I know if they are feeling amused.	1	2	3	4	5
8	When I see or hear someone who is amused, it makes me feel amused too.	1	2	3	4	5
9	Just by seeing or hearing someone, I know if they are feeling scared.	1	2	3	4	5
10	When I see or hear someone who is scared, it makes me feel scared too.	1	2	3	4	5
11	Just by seeing or hearing someone, I know if they are feeling calm.	1	2	3	4	5
12	When I see or hear someone who is calm, it makes me feel calm too.	1	2	3	4	5
13	Just by seeing or hearing someone, I know if they are feeling disgusted.	1	2	3	4	5
14	When I see or hear someone who is disgusted, it makes me feel disgusted too.	1	2	3	4	5
15	Just by seeing or hearing someone, I know if they are feeling enthusiastic.	1	2	3	4	5
16	When I see or hear someone who is enthusiastic, it makes me feel enthusiastic too.	1	2	3	4	5
17	Just by seeing or hearing someone, I know if they are feeling embarrassed.	1	2	3	4	5
18	When I see or hear someone who is embarrassed, it makes me feel embarrassed too.	1	2	3	4	5
19	Just by seeing or hearing someone, I know if they are feeling proud.	1	2	3	4	5
20	When I see or hear someone who is proud, it makes me feel proud too.	1	2	3	4	5

APPENDIX-9

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APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

REVISED BEHAVIOUR PROBLEM CHECKLIST

Child's Name _____ ID # _____

Grade _____ Gender _____ Race_____ Age _____ Date of Birth ___/___/___

Rater's Name _____ Relationship to Child _____ Date Completed___/___/___

	Not a problem	Mild problem	Severe problem
1. Restless; unable to sit still	0	1	2
2. Seeks attention; shows off	0	1	2
3. Stays out late at night	0	1	2
4. Self-conscious; easily embarrassed	0	1	2
5. Disruptive; annoys and bothers others	0	1	2
6. Feels inferior	0	1	2
7. Steals in company with others	0	1	2
8. Preoccupied; "in a world of his or her own," stares into space	0	1	2
9. Shy; bashful	0	1	2
10. Withdraws; prefers solitary activities	0	1	2
11. Belongs to a gang	0	1	2
12. Has repetitive speech; says same thing over and over	0	1	2
13. Has short attention span; poor concentration	0	1	2
14. Lacks self-confidence	0	1	2
15. Inattentive to what others say	0	1	2
16. Has incoherent speech; what is said doesn't make sense	0	1	2
17. Fights	0	1	2
18. Loyal to delinquent friends	0	1	2
19. Has temper tantrums	0	1	2
20. Truant from school, usually in company with others	0	1	2
21. Hypersensitive; feelings are easily hurt	0	1	2
22. Generally fearful; anxious	0	1	2
23. Irresponsible; undependable	0	1	2
24. Has "bad" companions, ones who are always in some kind of trouble	0	1	2
25. Tense; unable to relax	0	1	2
26. Disobedient; difficult to control	0	1	2
27. Depressed; always sad	0	1	2
28. Uncooperative in group situation	0	1	2
29. Passive, suggestible; easily led by others	0	1	2
30. Hyperactive; always on the go	0	1	2
31. Distractible; easily diverted from the task at hand	0	1	2
32. Destructive in regard to own and/or other's property	0	1	2
33. Negative; tends to do the opposite of what is requested	0	1	2
34. Impertinent; talks back	0	1	2
35. Sluggish; slow moving, lethargic	0	1	2
36. Drowsy; not wide awake	0	1	2
37. Nervous, jittery, jumpy; easily startled	0	1	2
38. Irritable, hot-tempered; easily angered	0	1	2
39. Expresses strange, far-fetched ideas	0	1	2
40. Argues; quarrels	0	1	2
41. Sulks; pouts	0	1	2
42. Persists and nags; can't take "no" for an answer	0	1	2
43. Avoids looking others in the eye	0	1	2
44. Answers without stopping to think	0	1	2
45. Unable to work independently; needs constant help and attention	0	1	2

	Not a problem	Mild problem	Severe problem
46. Uses drugs in company with others	0	1	2
47. Impulsive; starts before understanding what to do, doesn't stop and think	0	1	2
48. Chews on inedible things	0	1	2
49. Tries to dominate others; bullies, threatens	0	1	2
50. Picks at other children as a way of getting their attention; seems to want to relate but doesn't know how	0	1	2
51. Steals from people outside the home	0	1	2
52. Expresses beliefs that are clearly untrue (delusions)	0	1	2
53. Says nobody loves him or her	0	1	2
54. Freely admits disrespect for moral values and laws	0	1	2
55. Brags; boasts	0	1	2
56. Slow; not accurate in doing things	0	1	2
57. Shows little interest in things around him or her	0	1	2
58. Does not finish things; gives up easily, lacks perseverance	0	1	2
59. Is part of a group that rejects school activities such as team sports, clubs, projects to help others	0	1	2
60. Cheats	0	1	2
61. Seeks company of older, more experienced companions	0	1	2
62. Knows what's going on but is listless and uninterested	0	1	2
63. Resists leaving mother's (or other caretaker's) side	0	1	2
64. Has difficulty in making choices; can't make up mind	0	1	2
65. Teases others	0	1	2
66. Absentminded; forgets simple things easily	0	1	2
67. Acts like he or she were much younger; immature, childish	0	1	2
68. Has trouble following directions	0	1	2
69. Lies to protect his or her friends	0	1	2
70. Afraid to try new things for fear of failure	0	1	2
71. Selfish; won't share, always takes the biggest piece	0	1	2
72. Uses alcohol in company with others	0	1	2
73. School work is messy, sloppy	0	1	2
74. Does not respond to praise from adults	0	1	2
75. Not liked by others; is a "loner" because of aggressive behavior	0	1	2
76. Does not use language to communicate	0	1	2
77. Cannot stand to wait; wants everything right now	0	1	2
78. Refuses to take directions; won't do as told	0	1	2
79. Blames others; denies own mistakes	0	1	2
80. Admires and seeks to associate with "rougher" peers	0	1	2
81. Punishment doesn't affect his or her behavior	0	1	2
82. Squirms; fidgets	0	1	2
83. Deliberately cruel to others	0	1	2
84. Feels he or she can't succeed	0	1	2
85. Tells imaginary things as though true; unable to tell real from imagined	0	1	2
86. Affectionless; does not hug and kiss members of family	0	1	2
87. Runs away; is truant from home	0	1	2
88. Openly admires people who operate outside the law	0	1	2
89. Repeats what is said to him or her; "parrots" others' speech	0	1	2

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APPLICATION OF PARENT MEDIATED INTEGRATED PSYCHOBEHAVIOURAL INTERVENTION ON ADOLESCENTS WITH CONDUCT DISORDER: A MIXED METHODS STUDY

COPING WITH ADOLESCENTS' NEGATIVE EMOTION SCALE

Caregiver Attitude/Behavior Questionnaire

Instructions: In the following items, please indicate on a scale from 1 (very unlikely) to 7 (very likely) the likelihood that you would respond in the ways listed for each item. Please read each item carefully and respond as honestly and sincerely as you can. For each response, please circle a number from 1-7.

Response Scale:	1	2	3	4	5	6	7
	Very Unlikely			Medium			Very Likely

1. When I see my teenager becoming angry at a close friend, I usually:

a. become uncomfortable and uneasy in dealing with his/her anger	1 2 3 4 5 6 7
b. encourage him/her to express his/her anger	1 2 3 4 5 6 7
c. talk to him/her to calm him/her down	1 2 3 4 5 6 7
d. tell him/her not to make such a big deal out of it	1 2 3 4 5 6 7
e. get angry at him/her for losing his/her temper	1 2 3 4 5 6 7
f. help him/her think of things to do to solve the problem	1 2 3 4 5 6 7

2. When my teenager gets down because he/she has had a bad day, I usually:

a. tell him/her that he/she really has nothing to be sad about	1 2 3 4 5 6 7
b. try to get him/her to think of good things that happened	1 2 3 4 5 6 7
c. listen to him/her talk about his/her feelings	1 2 3 4 5 6 7
d. become obviously uncomfortable when I see he/she is feeling down	1 2 3 4 5 6 7
e. help him/her think of things to do to get his/her problem solved	1 2 3 4 5 6 7

f. tell him/her to straighten up and stop sulking around the house 1 2 3 4 5 6 7

3. When my teenager gets anxious about performing in a recital or a sporting event, I usually:

a. help him/her think of things to do to make sure he/she does his/her best 1 2 3 4 5 6 7

b. yell at him/her for becoming so anxious 1 2 3 4 5 6 7

c. try to calm him down by helping him take his mind off things 1 2 3 4 5 6 7

d. tell him/her not to make such a big deal out of it 1 2 3 4 5 6 7

e. encourage him/her to talk about what is making him/her so anxious 1 2 3 4 5 6 7

f. get anxious about dealing with his/her nervousness 1 2 3 4 5 6 7

4. When my teenager gets angry because he/she can't get something that he/she really wants, I usually:

a. try to make him/her feel better by making him/her laugh 1 2 3 4 5 6 7

b. help him think of other ways to go about getting what he wants 1 2 3 4 5 6 7

c. get upset with him/her for becoming so angry 1 2 3 4 5 6 7

d. become uncomfortable and don't want to deal with him/her 1 2 3 4 5 6 7

e. tell him/her he/she is being silly for getting so angry 1 2 3 4 5 6 7

f. encourage him/her to talk about his/her angry feelings 1 2 3 4 5 6 7

5. When my teenager gets sad because he/she has had his/her feelings hurt by a friend, I usually:

a. get nervous dealing with his/her sad feelings 1 2 3 4 5 6 7

b. encourage my teenager to talk about what is bothering him/her 1 2 3 4 5 6 7

c. try to cheer him/her up 1 2 3 4 5 6 7

d. tell him/her that things aren't as bad as they seem 1 2 3 4 5 6 7

e. get angry at him/her for not being more in control of things 1 2 3 4 5 6 7

f. help him/her think of ways to help make the problem better 1 2 3 4 5 6 7

6. When I see my teenager become anxious about something at school, I usually:

a. tell him/her that he/she is making too big a deal out of it 1 2 3 4 5 6 7

b. become nervous and uneasy in dealing with his/her anxiety 1 2 3 4 5 6 7

c. get angry at him/her for not dealing with things better 1 2 3 4 5 6 7

d. encourage him/her to talk about what is making him/her nervous 1 2 3 4 5 6 7

e. help him/her think of things to do to solve the problem 1 2 3 4 5 6 7

f. help comfort and soothe his/her anxious feelings 1 2 3 4 5 6 7

7. When my teenager gets angry at a family member, I usually:

a. try to help them resolve the conflict 1 2 3 4 5 6 7

b. threaten to punish him/her 1 2 3 4 5 6 7

c. tell him/her he/she is over-reacting 1 2 3 4 5 6 7

d. try to help him/her calm down 1 2 3 4 5 6 7

e. encourage him/her to let his/her angry feelings out 1 2 3 4 5 6 7

f. become very uneasy and avoid dealing with him/her 1 2 3 4 5 6 7

8. When my teenager gets upset because he/she misses someone he/she cares about, I usually:

a. become nervous dealing with him/her and his/her feelings 1 2 3 4 5 6 7

b. encourage him/her to talk about his/her feelings for this person 1 2 3 4 5 6 7

c. try to get him/her to think of other things 1 2 3 4 5 6 7

d. tell him/her he/she has nothing to be upset about 1 2 3 4 5 6 7

e. get upset with him/her for not being in control of his/her feelings 1 2 3 4 5 6 7

f. help him think of ways to get in touch with the person he misses 1 2 3 4 5 6 7

9. When my teenager becomes nervous about some social situation that he/she has to face (such as a date or a party), I usually:

a. try to calm him down by pointing out how much fun he will have 1 2 3 4 5 6 7

b. give him/her advice about what to do in the social situation 1 2 3 4 5 6 7

c. get angry at him/her for being so emotional 1 2 3 4 5 6 7

d. prefer not to deal with his/her nervousness 1 2 3 4 5 6 7

e. encourage him/her to express his/her feelings 1 2 3 4 5 6 7

f. tell him/her he/she is making a big deal about nothing 1 2 3 4 5 6 7